Learning About Medicare Health Plans...

...*Six Steps to Choosing a Medicare Health Plan*

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

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More Medicare Health Plan Choices

Starting in 1999, Medicare offers more health plan choices. One of the new health plan choices might be right for you. The choice is yours. No matter what you decide, you are still in the Medicare program. All Medicare health plans must provide all Medicare covered services. However, all Medicare health plan choices may not be available in your area. For the most current list of your local Medicare health plan choices, look at the Internet at **www.medicare.gov**. Your local library or senior center may be able to help you get this information on their computers, or you may call the automated Medicare Special Information Number (1–800–318–2596 or TTY: 1–877–486–2048).

To be eligible for the other Medicare health plan choices:

- You must have Part A (Hospital Insurance) and Part B (Medical Insurance). If you are not sure if you have Part A and Part B, look on your Medicare card (red, white, and blue card). It will show "Hospital Insurance (Part A)" and/or "Medical Insurance (Part B)" on the lower left corner of the card. You can also call your local Social Security Administration (SSA) office, or call SSA at 1–800–772–1213.
- You must not have End-Stage Renal Disease. (ESRD is permanent kidney failure that requires dialysis or a transplant.) However, ESRD beneficiaries currently in a Medicare health plan will be able to remain in the plan they are in.
- You must live in the service area of a health plan. The service area is the geographic area where the plan accepts enrollees. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll you if you move out of the plan's service area. **If you are disenrolled, you are automatically covered under the Original Medicare Plan (the traditional pay-per-visit arrangement).** You can also choose to join a Medicare health plan in your new area.

Your out-of-pocket costs may depend on:

- Which Medicare health plan you choose.
- How often you need health care.
- What type of health care you need.
- Which extra benefits are covered by the plan.
- What your supplemental health insurance covers.
- Whether your doctor accepts assignment (Original Medicare Plan only).

If you are happy with the way you get health care now, you don't have to do anything. If you do nothing, you will continue to receive your Medicare health care in the same way you always have.

Medicare has new health plan choices.

Before you consider changing Medicare health plans, there are some things you need to think about. For instance, your current health care needs or the needs you may have in the future. Consider how each health plan would meet your needs. No matter what you decide, you are still in the Medicare program. You will continue to receive at least all the Medicare covered services as listed on the charts on pages 19–21.

If you are happy with the way you get health care now, you don't have to do anything! If you do nothing, the way you receive your health care now will not change.

Different health plan choices may affect your:

Cost: What you pay.

Extra Benefits: What extra benefits you get, like prescription drugs.

Providers: How much choice you have among doctors, and hospitals, and other health care providers.

The following steps will help you compare your Medicare health plan choices.

Steps to Choosing a Health Plan:

Step 1: Review your Medicare health plan choices.

Step 2: Evaluate what's important in a Medicare health plan.

Step 3: Review the Medicare health plan choices available where you live. For up-to-date comparison information, check the Internet at **www.medicare.gov**, or call 1–800–318–2596.

Step 4: Get information about available Medicare health plan choices.

Step 5: Make the Medicare health plan choice that is right for you.

Step 6: Enrolling (Disenrolling) in a Medicare health plan.

Steps 1–6 are on the following pages.

All of the Medicare health plan choices are listed below. However, they may not all be available in your area.

- **The Original Medicare Plan**
- **The Original Medicare Plan with a Supplemental Insurance Policy**
- **Medicare Managed Care Plans**
  - **Health Maintenance Organizations (HMOs)**
  - **HMOs with Point of Service Option (POS)**
  - **Provider Sponsored Organizations (PSOs)**
  - **Preferred Provider Organizations (PPOs)**
- **Private Fee-for-Service Plans**
- **Medicare Medical Savings Account Plans (MSAs)**
- **Religious Fraternal Benefit Society Plans (RFBs)**

These health plan choices are explained on pages 8–10.

Caution

If you answer yes to any of these questions, your health plan choices may be different or better.

If you answer yes to this question…	Please follow the instructions…
■ Are you (or your spouse) retired? Do you have health insurance through the former employer or union?	■ Contact your or your spouse's former employer or union before you make a health plan choice (see question 3 on page 14).
■ Are you (or your spouse) still working? Do you have health insurance through the employer or union?	■ Contact your or your spouse's employer or union before you make a health plan choice (see question 3 on page 14).
■ Do you have Medicaid or is your income low enough that you may qualify for Medicaid?	■ Contact your State Medical Assistance Office (see questions 14 and 15 on page 18).
■ Are you a military retiree?	■ Contact your local military base.
■ Are you a veteran entitled to Veterans Administration (VA) benefits?	■ Contact your local Veterans Administration office.
■ Do you have End-Stage Renal Disease (ESRD)?	■ You are only eligible for the Original Medicare Plan. You may be eligible for the Original Medicare Plan with Supplemental Insurance (see question 1 on page 13).
■ Do you have only Medicare Part A or only Part B?	■ You are only eligible for the Original Medicare Plan. You may be eligible for the Original Medicare Plan with Supplemental Insurance (see question 1 on page 13). If you wish to purchase Part A or Part B, contact the Social Security Administration (1–800–772–1213) or, if you are a Railroad Retirement beneficiary, contact the Railroad Retirement Board (call the nearest RRB field office or 1–800–808–0772).

Remember: The Original Medicare Plan doesn't pay for or cover everything. To get more coverage, you may purchase a Supplemental Insurance Policy, or you may consider joining a Medicare Managed Care Plan or Private Fee-for-Service Plan. Another choice is the Medicare Medical Savings Account (MSA) Plan (see "Enrolling (Disenrolling) in a Medicare Health Plan" on page 12). You should look at how all the health plan choices differ on cost, choice of doctors and hospitals, and benefits.

Cost — What You Pay

- All beneficiaries pay the Part B premium of $45.50 (in 1999).
- Monthly premiums tend to be lower in Medicare Managed Care Plans (if you follow the plan rules) than in most Supplemental Insurance Policies and some Private Fee-for-Service Plans.
- Your out-of-pocket costs (what you must pay) tend to be lower in most Managed Care Plans and the Original Medicare Plan with some Supplemental Insurance Policies. Costs often are higher in the Original Medicare Plan without a Supplemental Insurance Policy.
- In Medicare MSA Plans, there is no monthly premium. You pay for all the costs of services prior to meeting the high deductible for your plan. Your Medicare MSA can help pay the costs of services prior to your meeting the high deductible (see page 10).
- In Private Fee-for-Service Plans and Medicare MSA Plans, you may be asked to pay extra charges by doctors, hospitals, and other providers who don't accept the plan's fee as payment in full.

Providers—How You Choose Doctors and Hospitals

- The Original Medicare Plan, the Original Medicare Plan with a Supplemental Insurance Policy, Private Fee-for-Service Plans, and certain Medicare MSA Plans have the widest choice of doctors and hospitals.
- In most Medicare Managed Care Plans, and in some Medicare MSA Plans, you must choose your doctors and hospitals from a list provided by the plan. You may want to check if your current doctor is on the plan's list, and is accepting new Medicare patients under that plan. There is no guarantee that a particular doctor will stay with the plan.
- You can go to any specialist who accepts Medicare in the Original Medicare Plan, the Original Medicare Plan with a Supplemental Insurance Policy, Private Fee-for-Service Plans, and some Medicare MSA Plans. Most Medicare Managed Care Plans and some Medicare MSA Plans require a referral from your primary care doctor for you to see a specialist (see questions 9 and 11 on pages 16 and 17).
- In Private Fee-for-Service Plans and Medicare MSA plans, you may be asked to pay extra charges by doctors, hospitals, and other providers who don't accept the plan's fee as payment in full.

Extra Benefits—What Services You Get

- In Medicare Managed Care Plans or Private Fee-for-Service Plans, you may get extra benefits, like vision or dental care—beyond the benefits covered by the Original Medicare Plan or the Original Medicare Plan with a Supplemental Insurance Policy.

In lieu of extra benefits, enrollees in Medicare MSA Plans receive a deposit in their Medicare MSA from Medicare. Look on the Internet at **www.medicare.gov** for more information.

Prescription Drugs—An Important Extra Benefit

- In general, the Original Medicare Plan does not cover outpatient prescription drugs. Many Medicare Managed Care Plans and a few of the more expensive Supplemental Insurance Policies cover certain prescription drugs up to a specified dollar limit. In general, the Original Medicare Plan only covers medication while you are in a hospital or skilled nursing facility.

Other Important Things to Think About

- In the Original Medicare Plan, Medicare pays doctors and other health care providers directly for each service that you receive. For all other Medicare health plans, Medicare pays the health plan a lump sum amount of money; the plan oversees the services you receive.
- Plan benefits and costs can change each year. These changes are usually effective the first day of the new year.
- Medicare health plans may terminate their contract with Medicare at any time. If the plan terminates its contract with Medicare, you would be notified by the plan and automatically returned to the Original Medicare Plan. Question 2 on page 14 explains how this would affect your ability to get a Supplemental Insurance Policy should you want to stay with the Original Medicare Plan. You may join another plan in the area, but you will be covered by the Original Medicare Plan until the new coverage is in effect.
- Except for Medicare MSA Plans, you may leave (disenroll from) most Medicare health plans at any time and either return to the Original Medicare Plan, or switch to another plan. Special rules may apply (see question 3 on page 14) if you choose to return to your Supplemental Insurance Policy or your employer's health insurance. Contact your State Health Insurance Assistance Program, your State Insurance Department, or your employer for more information.
- As a Medicare beneficiary, you have rights. All Medicare health plans are required to have an appeal and grievance (complaint) process and must respond to your concerns (see question 8 on page 16).

Explanation of Medicare Health Plans

Original Medicare Plan

The traditional pay-per-visit arrangement that covers Part A and Part B services is now called the Original Medicare Plan.

Original Medicare Plan

The Original Medicare Plan is the traditional system, run by the Federal government, that covers your Part A and Part B services. Medicare pays its share of the bill and you pay the balance.

Cost: You pay the $45.50 Part B premium, Part A and Part B deductibles, and the coinsurance.

Providers: You can go to any doctor or hospital that accepts Medicare.

Extra Benefits: You receive all the Medicare covered services listed on pages 19–21, but no extra benefits.

Original Medicare Plan With a Supplemental Insurance Policy

The traditional pay-per-visit arrangement that covers Part A and Part B services is now called the Original Medicare Plan. You can buy a Supplemental Insurance Policy for extra benefits that help cover some of your out-of-pocket costs.

For more information on Supplemental Insurance Policies see question 1 on page 13 and question 2 on page 14.

Original Medicare Plan With a Supplemental Insurance Policy

The Original Medicare Plan is the traditional system that covers your Part A and Part B services. Medicare pays its share of the bill, and you pay the balance. You may purchase one of ten standard Supplemental Insurance Policies (Medigap or Medicare SELECT) for extra benefits. Some policies help pay Medicare's coinsurance amounts and deductibles.

Cost: You pay the Part B premium of $45.50. You also pay an additional monthly premium for your Supplemental Insurance Policy. The premium varies by State and insurer, and often varies by age. Most policies pay Medicare's coinsurance amounts and some also pay for Medicare's deductibles.

Providers:

- **Medigap:** You can go to any doctor or hospital that accepts Medicare.
- **Medicare SELECT:** You must use plan hospitals and in some cases plan doctors in order to be eligible for full Medigap benefits.

Extra Benefits: You receive all the Medicare covered services listed on pages 19–21. Some Supplemental Insurance Policies also cover services the Original Medicare Plan doesn't.

Explanation of Medicare Health Plans

Managed Care Plans

A group of health plans that include:

HMO:
Health Maintenance Organization

POS:
HMO with a Point of Service Option

PSO:
Provider Sponsored Organization

PPO:
Preferred Provider Organization

Managed Care Plans

A Managed Care Plan involves a group of doctors, hospitals, and other health care providers who have agreed to provide care to Medicare beneficiaries in exchange for a fixed amount of money from Medicare every month. Managed Care Plans include **HMOs, HMOs** with a **POS** option, **PSOs,** and **PPOs.**

Cost: You pay the Part B premium of $45.50. Some plans charge you an extra monthly premium. You may also pay the plan a copayment per visit or service. You will also pay more if you don't follow plan rules. No Supplemental Insurance Policy is necessary if you join a Managed Care Plan.

Providers: Your choice of doctors and hospitals varies by the type of Medicare Managed Care Plan you choose. HMOs and PSOs are usually more restrictive—you must use the plan's doctors and hospitals. PPOs and HMOs with POS options are generally less restrictive—you may use doctors and hospitals outside of the plan for an additional cost.

Extra Benefits: You receive all the Medicare covered services listed on pages 19–21. Many Medicare Managed Care Plans offer additional benefits not covered under the Original Medicare Plan.

Private Fee-for-Service Plan

A private insurance plan that accepts Medicare beneficiaries.

Private Fee-for-Service Plan

You choose a private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much to reimburse for the services you receive. You may have extra benefits the Original Medicare Plan doesn't cover.

Cost: You pay the Part B premium of $45.50, any monthly premium the Private Fee-for-Service Plan charges, and an amount per visit or service. Providers are allowed to bill beyond what the plan pays, and you will be responsible for paying whatever the plan doesn't cover. You may pay more for services.

Providers: You can go to any doctor or hospital.

Extra Benefits: You receive all the Medicare covered services listed on pages 19–21. Some Private Fee-for-Service Plans may offer additional benefits the Original Medicare Plan doesn't cover.

Explanation of Medicare Health Plans

Medicare Medical Savings Account (MSA) Plan

A test program for 390,000 Medicare beneficiaries. If you choose a Medicare MSA Plan, you must stay in it for a full year. Medicare MSA Plans first become available in November 1998.

Medicare Medical Savings Account (MSA) Plan

This is a test program for 390,000 eligible Medicare beneficiaries. You choose a Medicare MSA Plan—a health insurance policy with a high deductible. Medicare pays the premium for the Medicare MSA Plan and makes a deposit to the Medicare MSA that you establish. You use the money deposited in your Medicare MSA to pay for medical expenses. If you don't use all the money in your Medicare MSA, next year's deposit will be added to your balance. Money can be withdrawn from a Medicare MSA for non-medical expenses, but that money will be taxed. **If you enroll in a Medicare MSA Plan, you must stay in it for a full year.** You can only sign up for a Medicare MSA Plan in November of each year, or during special enrollment periods. Call 1–800–318–2596 for more information on Medicare MSA Plans. Medicare MSA Plans first become available in November 1998.

Cost: You pay the Part B premium of $45.50. You use the money in your Medicare MSA to pay for medical expenses. Unlike other Medicare health plans, there are no limits on what providers can charge you above the amount paid by your Medicare MSA Plan. If you use all your Medicare MSA money, you are responsible for paying all of your medical expenses until you meet the deductible for your Medicare MSA Plan. The deductible can be considerably higher than those of other Medicare health plans. Your Medicare MSA can help pay these costs.

Providers: Depending on the Medicare MSA Plan you choose, you may be able to go to any doctor or hospital, or you may be limited to a network of providers.

Extra Benefits: Money in your Medicare MSA pays for things that the Original Medicare Plan covers, plus other services it does not cover. A Medicare MSA Plan may offer additional benefits the Original Medicare Plan doesn't cover, but it doesn't pay for them until you meet your annual deductible.

Religious Fraternal Benefit Society Plans

Religious Fraternal Benefit Society Plans

These plans are offered by a Religious Fraternal Benefit Society for members of the society and only members may enroll. The society must meet Internal Revenue Service (IRS) and Medicare requirements for this type of organization. No other information on Religious Fraternal Benefit Society Plans is available at this time.

Step 3: Review the Medicare Health Plan Choices Available Where You Live

To review the Medicare Health Plan Choices available where you live:

- Look on the Internet, at **www.medicare.gov**. Your local library or Senior Center may be able to help you get this information using their computers. You may also contact your State Health Insurance Assistance Program for questions or assistance with information about health plans.
- Call the Medicare Special Information number at 1–800–318–2596 (TTY: 1–877–486–2048) and request Medicare health plan comparison information.

Step 4: Get Information About Available Medicare Health Plan Choices

For even more detailed information on Medicare health plans, call the specific plan(s) you are interested in. Their telephone number is listed on **www.medicare.gov** or may be found in your local telephone book. If you receive a letter or brochure from a Medicare health plan in the mail, the plan's telephone number will be included.

Step 5: Make the Medicare Health Plan Choice That is Right for You

Before you make a final decision about a Medicare Health Plan, you may wish to:

- Talk to family, friends, or your doctor about your health plan choices.
- Look on the Internet, at **www.medicare.gov**. This Internet site has a telephone directory with information on who to call for assistance. Your local library or Senior Center may be able to help you get this information using their computers.
- Read *Medicare & You*. Beneficiaries will receive *Medicare & You* in the mail in November of 1998. It is currently available on **www.medicare.gov**.
- Complete the Medicare Worksheet for Comparing Medicare Health Plans. The worksheet can be found on the Internet, at **www.medicare.gov**.
- Contact you State Health Insurance Assistance Program for assistance.

You don't need to do anything if you want to keep the Original Medicare Plan or your current Medicare Managed Care Plan. If you have another health plan, you must disenroll to return to the Original Medicare Plan.

See question 2 on page 14 for special rules that may apply if you choose to disenroll from a health plan and return to your Supplemental Insurance Policy.

How to enroll/disenroll: Medicare Managed Care or Private Fee-for-Service Plan

You can enroll in a Medicare Managed Care Plan or a Private Fee-for-Service Plan at any time.

To enroll:

- Call the plan to request an enrollment form (plan numbers are available on the Internet at **www.medicare.gov**, or in your local phone book).
- Complete and mail the form to the plan.
- You will receive a letter from the plan telling you when your membership begins.
- The plan cannot refuse to enroll you.

To disenroll:

- You may disenroll (leave) a plan at any time for any reason.
- Call the plan or the Social Security Administration (1–800–772–1213) and tell them you want to disenroll.
- Your disenrollment becomes effective as early as the first of the month after your request for disenrollment is received.

How to enroll/disenroll: Medicare Medical Savings Account (MSA) Plan

You can only enroll in a Medicare MSA Plan:

- During the 3-month period before you are entitled to Part A and part B, or
- During November of each year starting in 1998. **(The first time you enroll in November, you have until December 15 of the same year to change your mind. If you do not change your mind, you must stay in the Medicare MSA for one full calendar year.)**

To enroll:

- Call 1–800–318–2596 and request more Medicare MSA information.
- You set up a special Medicare MSA at a bank/savings institution.
- You choose from among available Medicare MSA plans.
- Your enrollment will be effective January 1.

To disenroll:

- File a request for disenrollment in November. It is effective December 31.

Question 1: What is a Medicare Supplemental Insurance Policy?

Answer: Supplemental Insurance Policies only work with the Original Medicare Plan. Many private insurance companies sell Medicare Supplemental (Medigap) Insurance Policies for the specific purpose of filling the "gaps" in the Original Medicare Plan coverage. Similar coverage may also be available to retirees through an employer or union health plan.

In all States except Minnesota, Massachusetts, and Wisconsin, Federal law forbids insurers from selling you Medicare Supplemental (Medigap) Policies that are not one of the 10 standard supplemental policies. These 10 types of policies must be labeled with the letters A through J, to make it simple for consumers to compare policies. State law may limit the types of policies that are actually sold in your State.

These policies may pay for some or all of the Medicare coinsurance amounts; some or all deductibles; and certain services not covered by the Original Medicare Plan at all. These may include outpatient prescription drugs, some preventive screenings, some care in your home, and emergency medical care for travel outside the United States. Some policies provide coverage of health care provider charges over the amount Medicare will pay.

Medicare SELECT refers to a type of Medigap Policy. It must meet all of the requirements that apply to a Medigap Policy, and it must be one of the 10 prescribed benefit packages. The only difference is that a Medicare SELECT Policy may require you to use doctors and hospitals within its network in order for you to be eligible for full benefits. Because of this limitation, a Medicare SELECT Policy will usually cost less than a regular Medigap Policy.

For more information on Supplemental Insurance Policies, call 1–800–638–6833 and request a copy of *The Guide to Health Insurance for People with Medicare*.

Question 2: What happens to my Supplemental Insurance Policy (Medigap) if I join a Medicare health plan, drop my Supplemental Insurance Policy, and then later disenroll from the health plan?

Answer: You can return to your Medigap policy if you dropped it to enroll in a Medicare health plan or a Medicare SELECT policy. However:

(1) This must be the **first time** that you enrolled in a health plan or a SELECT policy;

(2) You must leave the health plan or SELECT policy **within one year after joining;** and

(3) After leaving your health plan or SELECT policy, you must choose a Medigap policy **within 63 days.**

If you meet these requirements, you can return to your original Medigap policy, if it is still offered, or policies A, B, C, or F. Your State Health Insurance Assistance Program can provide you with more information.

Question 3: If I switch from health insurance provided by my or my spouse's current or former employer or union, to a Medicare health plan, can I switch back to the employer/union insurance if I disenroll from the Medicare health plan?

Answer: If you or your spouse has employer or union-provided health insurance and you disenroll from that group health plan to join another Medicare health plan, you may or may not be able to get the same policy back for the same premium. Contact your or your spouse's current or former employer or union before you make a health plan choice.

Question 4: Can I leave a Managed Care Plan or Private Fee-for-Service Plan and return to the Original Medicare Plan?

Answer: Yes. You may disenroll from a Medicare Managed Care Plan or Private Fee-for-Service Plan at any time, for any reason. However, beginning January 1, 2002, disenrollment opportunities will be limited.

To disenroll, give a signed written request to the plan, or a Social Security Administration Office. If you are a Railroad Retirement beneficiary, give your request to the Railroad Retirement Board.

Question 5: Can I find out how a Medicare Managed Care Plan pays its doctors?

Answer: Medicare Managed Care Plans' current members and those interested in joining the plan have a legal right to know (in writing) how the plan pays its doctors. If you want this information, call the plan.

Question 6: Does travel affect my health care? How does the health plan handle coverage when I'm not in the service area?

Answer: If you travel a lot or live in another State part of the year, you should contact the plan and ask if the plan provides coverage for services when you are out of the service area. The Original Medicare Plan does not cover care outside the United States. Some Managed Care Plans and Private Fee-for-Service Plans, as well as some of the more expensive Supplemental Insurance Policies, cover care outside of the U.S. (Railroad Retirement Board (RRB) beneficiaries have different rules. Contact the RRB (1–800–808–0772) or RRB carrier (United HealthCare at 1–800–833–4455) for information.)

Question 7: If I join a Medicare Managed Care Plan or Private Fee-for-Service Plan, will I lose any of my Medicare covered services?

Answer: No. When you enroll in a Managed Care Plan or Private Fee-for-Service Plan, you are still entitled to all the covered services of the Medicare program. All Medicare Managed Care Plans and Private Fee-for-Service Plans must provide, at least, all the services covered under the Original Medicare Plan. This includes Part A (Hospital Insurance) and Part B (Medical Insurance). Hospice benefits are provided by a Medicare approved hospice in your service area. Medicare Managed Care Plans and Private Fee-for-Service Plans also may provide additional benefits.

Question 8: How do I question or appeal a Medicare Managed Care Plan or Private Fee-for-Service Plan or Medicare Medical Savings Account Plan coverage decision?

Answer: You have a right to appeal many decisions about your Medicare covered services. You have this right whether you are enrolled in a Medical Managed Care Plan, Private Fee-for-Service Plan, or a Medicare Medical Savings Account Plan. Your health plan must provide you with written instructions on how to appeal. You may file an appeal if your health plan denies a service, or terminates or refuses to pay for services that you believe should be covered. After you file an appeal, the health plan reviews its decision. Then, if your health plan does not decide in your favor, the appeal automatically goes to an independent review organization that contracts with Medicare. You may be eligible for a fast decision (within 72 hours) if your health or ability to function could be seriously harmed by waiting the amount of time needed for a standard decision. See the health plan's membership materials or contact your health plan for details about your Medicare appeal rights.

If you believe you are being discharged too soon from a hospital, you have a right to immediate review by the Peer Review Organization (PRO). During the immediate review, you may be able to stay in the hospital at no charge and the hospital cannot discharge you before the PRO reaches a decision.

Question 9: Can I find out how a Medicare Managed Care Plan pays its doctors?

Answer: Primary care doctors are trained to provide basic care. In many Medicare Managed Care Plans and some Medicare Medical Savings Account Plans, they coordinate and provide most or all of your health care. Many plans require you to see your primary care doctor for a referral to a specialist. When you join a Medicare Managed Care Plan, you may be asked to choose a primary care doctor from among the doctors who belong to the plan. If you already have a doctor you would like to keep seeing, ask your doctor if he or she is in the plan and accepting new patients under that plan.

Question 10: May I change my primary care doctor if I am in a Medicare Managed Care Plan or Medicare Medical Savings Account Plan? What if my primary care doctor leaves the health plan?

Answer: Yes, you may change. To change your primary care doctor, check your health plan member handbook for instructions. You may also call the plan's member services number. In some cases, the effective date of such a change may be the end of the current month. If your doctor leaves the plan, you may choose a new doctor in the plan.

Question 11: What is a referral?

Answer: A referral is permission from your primary care doctor to see a certain specialist or receive certain services. Some Medicare health plans may require referrals. Important: if you either see a different doctor than the one on the referral, or the service isn't for an emergency or urgently needed care, you may be responsible for the entire bill.

Question 12: What is a medical emergency? How do I get emergency care if I am in a Medicare Managed Care Plan?

Answer: A medical emergency includes severe pain, an injury, sudden illness, or suddenly worsening illness that you believe may cause serious danger to your health if you do not get immediate medical care. Your plan is required to provide access to emergency and urgently needed care services 24 hours a day, 7 days a week. Your plan must pay for your emergency care and cannot require prior authorization for emergency care you receive from any provider. You can receive emergency care anywhere in the United States. When you receive emergency care, the doctor or hospital that provides the service will bill either you or your plan. If you receive the bill, give it to your plan, and keep a copy for your own record. Following a medical emergency, your plan must also pay for care you need before your condition is stable enough for you to return to your plan's provider. If your condition lets you return to the plan service area, you will need to get follow-up care from your Medicare Managed Care Plan. You should let your plan know of emergencies as soon as medically possible. If what you believed was an emergency turns out not to be, the plan must still pay. Your plan can require that you pay the entire cost of care received in an emergency room for a problem that you knew was not an emergency. You can appeal a denial of payment for emergency services (see question 8 on page 16).

Question 13: What is "urgently needed care"? How do I get urgently needed care if I am in a Medicare Managed Care Plan?

Answer: Unexpected illness or injury that needs immediate medical attention, but is not life threatening, is urgently needed care. Your primary care doctor generally provides urgently needed care. If you are temporarily out of the plan's service area and cannot wait until you return home, the health plan must pay for urgently needed care.

Question 14: What is Medicaid?

Answer: Medicaid is a joint Federal and State program that provides payment for some medical costs for certain individuals who are older, have low incomes and limited assets, or are disabled. Coverage and eligibility vary from State to State, but most of your health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid recipients may also receive benefits such as nursing home care and outpatient prescription drugs.

Question 15: How can Medicaid help low-income Medicare beneficiaries?

Answer: Medicaid has programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain individuals entitled to Medicare Part A who have a low income. You must have Medicare hospital insurance (Part A). If you are not sure if you have Part A, look on your Medicare card (red, white, and blue card). It will show "Hospital Insurance (Part A)" on the lower left corner of the card. You can also call your local Social Security Administration (SSA) office, or call SSA at 1–800–772–1213.

If you have Part A, and your bank accounts, stocks, bonds, or other resources do not exceed $4,000 for an individual, or $6,000 for a couple, you may qualify for assistance as a Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI).

1998 Monthly Income Limit*

	Individual	*Couple*	*Benefit—Pays Medicare's . . .*
Qualified Medicare Beneficiary	$691	$925	Premiums, deductibles, and coinsurance
Specified Low-Income Medicare Beneficiary	$825	$1,105	Part B premium
Qualifying Individual–1	$926	$1,241	Part B premium
Qualifying Individual–2	$1,194	$1,603	A small part of the Part B premium

If you think you may qualify, contact your State, county, or local medical assistance office, not a Federal office.

*Slightly higher amounts are allowed in Alaska and Hawaii. Income limits will change slightly in 1999.

All Medicare health plans provide coverage for these basic services shown on the charts on pages 19–21. Some Medicare health plans may provide additional benefits.

Covered Services	What You Pay
Hospital Stays: Semiprivate room, meals, general nursing and other hospital services and supplies (but not private duty nursing, a television or telephone in your room, or a private room unless medically necessary).	**For each benefit period you pay:** ■ A total of $768 for a hospital stay of 1–60 days. ■ $192 **per day** for days 61–90 of a hospital stay. ■ $384 **per day** for days 91–150 of a hospital stay.* ■ All costs for **each day** beyond 150 days.
Skilled Nursing Facility (SNF) Care†: Semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies.	**For each benefit period you pay:** ■ Nothing for the first 20 days. ■ Up to $96 per day for days 21–100. ■ All costs beyond the 100th day in the benefit period. Contact your Fiscal Intermediary with questions about Skilled Nursing Facility Care and conditions of coverage.
Home Health Care†: Intermittent skilled nursing care, physical therapy, speech language pathology services, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.	**You pay:** ■ Nothing for Home Health Care services. ■ 20% of approved amount for durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Call your Regional Home Health Intermediary with questions about Home Health Care and conditions of coverage.
Hospice Care†: Pain and symptom relief, and supportive services for the management of a terminal illness. Home care is provided. Also covers necessary inpatient care and a variety of services otherwise not covered by Medicare.	**You pay:** ■ Limited costs for outpatient drugs and inpatient respite care (care given to a hospice patient so that the usual care giver can rest). Call your Regional Home Health Intermediary about Hospice Care and conditions of coverage.
Blood: From a hospital or skilled nursing facility during a covered stay.	**You pay:** ■ For the first 3 pints.

*You have 60 reserve days that may only be used once. For each reserve day, Medicare pays all covered costs except for a daily coinsurance ($384 in 1999).

†You must meet certain conditions in order for Medicare to cover these services.

Benefit Period: Starts the day you are admitted to a hospital or Skilled Nursing Facility and ends when you haven't received hospital inpatient or Skilled Nursing Facility care for 60 consecutive days.

Call your Fiscal Intermediary for general questions about your Medicare Part A coverage.

Medicare Part B (Medical Insurance) Covered Services

Covered Services	What You Pay
Medical Expenses: Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, and durable medical equipment (DME).	**You pay:** ■ $100 deductible (pay once per year). ■ 20% of approved amount after the deductible, except in the outpatient setting. ■ 50% for most outpatient mental health. ■ 20% of first $1,500 for all physical therapy services and 20% of first $1,500 for all occupational therapy services, and all charges thereafter. (Hospital outpatient therapy services do not count towards limit.)
Clinical Laboratory Service: Blood tests, urinalysis, and more.	**You pay:** ■ Nothing for services.
Home Health Care: (If you don't have Part A.) Intermittent skilled care, home health aide services, DME and supplies, and other services.	**You pay:** ■ Nothing for services. ■ 20% of approved amount for DME.
Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury.	**You pay:** ■ No less than 20% of the Medicare payment amount (after the deductible).
Blood: As an outpatient, or as part of a Part B covered service.	**You pay:** ■ For the first 3 pints plus 20% of approved amount for additional pints (after the deductible).

Note: Actual amounts you must pay for coinsurance are higher if the doctor does not accept assignment (see page 22).

Call your Medicare carrier if you have general questions about your Medicare Part B coverage.

Part B also helps pay for:

- X-rays
- Speech language pathology services
- Artificial limbs and eyes
- Arm, leg, back, and neck braces
- Kidney dialysis and kidney transplants
- Under limited circumstances, heart, lung, and liver transplants in a Medicare-approved facility
- Preventive services (see next page)
- Very limited outpatient drugs
- Emergency care
- Limited chiropractic services
- Medical supplies: items such as ostomy bags, surgical dressings, splints, and casts
- Breast prostheses following a mastectomy
- Ambulance services (limited coverage)
- The services of practitioners such as clinical psychologists, clinical social workers, and nurse practitioners
- One pair of eyeglasses after cataract surgery with an intraocular lens

Covered Service	Eligible Beneficiaries	What You Pay
Screening Mammogram: Once per year.	All female Medicare beneficiaries age 40 and older.	20% of the Medicare approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam). Once every three years. Once per year if you are high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap smear in the preceding three years.	All female Medicare beneficiaries.	No coinsurance and no Part B deductible for the Pap smear (clinical laboratory charge). For doctor services and all other exams, 20% of the Medicare approved amount with no Part B deductible.
Colorectal Cancer Screening: **Fecal Occult Blood Test** Once every year. **Flexible Sigmoidoscopy** Once every four years. **Colonoscopy** Once every two years if you are high risk for cancer of the colon. **Barium Enema** Doctor can substitute for sigmoidoscopy or colonoscopy.	All Medicare beneficiaries age 50 and older. However, there is no age limit for having a colonoscopy.	No coinsurance and no Part B deductible for the fecal occult blood test. For all other tests, 20% of the Medicare approved amount after the annual Part B deductible.
Diabetes Monitoring: Includes coverage for glucose monitors, test strips, lancets, and self-management training.	All Medicare beneficiaries with diabetes (insulin users and non-users).	20% of the Medicare approved amount after the annual Part B deductible.
Bone Mass Measurements: Varies with your health status.	Certain Medicare beneficiaries at risk for losing bone mass.	20% of the Medicare approved amount after the annual Part B deductible.
Vaccinations: **Flu Shot:** Once per year. **Pneumococcal Vaccination:** One may be all you ever need —ask your doctor. **Hepatitis B Vaccination:** If you are at high or intermediate risk for hepatitis.	All Medicare beneficiaries.	No coinsurance and no Part B deductible for flu or pneumococcal vaccinations. For Hepatitis B vaccination, 20% of the Medicare approved amount after the Part B deductible.

Definitions of Important Terms

Assignment—In the Original Medicare Plan, doctors and other providers who accept assignment accept the amount Medicare approves for a particular service or supply as payment in full. (You are still responsible for any coinsurance amount.)

Benefit Period—Starts the day you are admitted to a hospital or skilled nursing facility and ends when you haven't received hospital inpatient or skilled nursing facility care for 60 consecutive days.

Coinsurance—The percent of the approved charge that you have to pay either after you have paid the Part A deductible, or after you pay the first $100 deductible each year for Part B.

Deductible—The amount you must pay before Medicare begins to pay either each benefit period for Part A, or each year for Part B.

Fiscal Intermediary—A private insurance company that has contracted with Medicare to process bills (claims) for Part A services.

Medicare Carrier—A private insurance company that has contracted with Medicare to process beneficiary bills (claims) for Part B services.

Part A—Medicare Hospital Insurance that helps pay for care in hospitals and skilled nursing facilities, and for home health and hospice care.

Part B—Medicare Medical Insurance that helps pay for doctors, outpatient hospital care and some other medical services that Part A doesn't cover, such as the services of physical and occupational therapists.

Peer Review Organizations (PROs)—Groups of practicing doctors and other health care professionals paid by the federal government to monitor the care given to Medicare patients. They are responsible for reviewing beneficiary complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments and hospital emergency rooms; skilled nursing facilities; home health agencies; Medicare Managed Care Plans and ambulatory surgical centers.

Premium—Monthly payment for health care coverage to Medicare, an insurance company, or a health care plan.

Regional Home Health Intermediaries—An organization contracted by Medicare that processes claims and performs audits of home health providers.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

7500 Security Boulevard
Baltimore, Maryland 21244–1850

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